SUPPLEMENT B - EPSDT
TABLE OF CONTENTS

COVERED SERVICES AND LIMITATIONS

GENERAL INFORMATION ON EPSDT SERVICES

In addition to being eligible for the Medicaid services offered under the state's Medicaid program, children under the age of 21 are entitled to the mandatory Federal Medicaid benefit known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT is a Medicaid program that was established by Congress in 1967. Federal law requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements.

EPSDT is Medicaid's comprehensive and preventive children's health program geared to the early assessment of children's health care needs through periodic examinations. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly.

Defining each word in the title of the program will help to explain the concept of EPSDT:

Early – means as soon as possible in the child's life or as soon as the child's eligibility for assistance has been established.

Periodic – means at intervals established for screening by medical, dental and other health care experts. The types of procedures performed and their frequency will depend on the child's age and health history. The required minimal frequency for screenings is outlined.

Screening – is the use of quick, simple procedures to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive study of their physical and mental problems.

Diagnosis – is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history; physical, developmental, and psychological examination, and laboratory tests and x-rays. Physicians who do EPSDT screenings may diagnose and treat health problems discovered during the screening, or they may refer the child to other appropriate sources for such care.

Treatment – is any medically necessary treatment service required to correct or ameliorate defects and physical and mental illnesses and conditions discovered during a screening examination. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS as medically necessary.

The required EPSDT services under Section 1905(r) of the Social Security Act that are available to Medicaid enrolled children under age 21 are described below.

1. Screening Services

- EPSDT screening services contain the following five (5) elements:

1. A comprehensive health and developmental history, including assessment of both physical and mental health and development;
2. A comprehensive unclothed physical examination;
3. Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
4. Laboratory tests, (including blood level assessment; appropriate for age and risk factors), and
5. Health education, including anticipatory guidance.

2. Vision Services

- Vision services are provided at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved with child health care.

- Vision services are provided at other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and a minimum must include diagnosis and treatment for defects in vision, including eyeglasses.

3. Dental Services

- Dental services are provided at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care.

- Dental services are provided at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

- Dental services must at a minimum include relief of pain and infection, restoration of teeth, and maintenance of dental health.

4. Hearing Services

- Hearing services are provided at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care.

- Hearing services are provided at such intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

- Hearing services, at a minimum, must include diagnosis and treatment for defects in hearing, including hearing aids.

<u>Other Necessary Health Care, Diagnostic Services and Treatment Services</u>

As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose.

In addition, the state must provide other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan.

The state may determine the medical necessity of the service and subject the service to prior authorization for purposes of utilization review.

Outreach and Informing

Federal EPSDT regulations provide that all eligible Medicaid recipients under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation.

Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS) as well as participating HMOs, primary care physicians (PCPs) and EPSDT screening providers.

DSS provides information about EPSDT services to Medicaid applicants during the initial eligibility interview including the following:

- Inform families of the benefits of regular preventive health care for their children;
- The range of services available, and how to obtain these services;
- The services are provided at no cost to them; and
- Necessary transportation and appointment scheduling assistance is available through the DMAS Managed Care Help Line (1-800-643-2273).

DMAS provides new Medicaid enrollees with an EPSDT brochure describing the services and how to access them. The Managed Care Help Line staff informs recipients of EPSDT services and encourages them to contact their primary care physician or a Medicaid enrolled EPSDT provider as soon as possible to schedule screening appointments for their children. DMAS also sends periodic mailings to all Medicaid enrolled families to encourage their participation in EPSDT.

HMO informing and outreach responsibilities must include, at a minimum, promotion of EPSDT for new enrollees, including urging them to contact their primary care provider to schedule an initial screening, a clear description of EPSDT services in the member handbook and ongoing member education services encouraging participation in these services.

MEDALLION primary care physicians must promptly contact new Medicaid MEDALLION enrollees assigned to their panel of patients to discuss the benefits of preventive health care and schedule the child's initial EPSDT screening within thirty (30) days.

Qualified EPSDT Screening Providers

Qualified providers of EPSDT screening services include:

- Physicians
- Mid-level practitioners including certified nurse practitioners and certified nurse midwives
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Local health departments
- School based clinics
- Other DMAS approved clinics

EPSDT providers must be Medicaid enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

The Primary Care Physician's Role in Screening

The majority of Medicaid recipients eligible for EPSDT services in Virginia are enrolled in the MEDALLION program or in HMOs. PCPs participating in MEDALLION must provide or arrange for screenings to all Medicaid patients who are under the age of 21 in their panels. PCPs for children in HMOs must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid enrolled physician or clinic who is qualified to provide EPSDT services and also offers these services. These qualified Medicaid enrolled fee-for-service EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. There are no special enrollment procedures for recipients to access EPSDT services.

The MEDALLION PCP, HMO PCP, or EPSDT screening provider for non-MEDALLION and non-Medallion II recipients, must perform the following activities related to screening services:

- Advise families of the importance of regular preventive health care for their children and explain EPSDT services.

- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.

- Assure that the initial screening is scheduled within thirty (30) days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.

- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments.

- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.

- Follow up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly.

- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other health care services.

- Maintain a comprehensive and integrated medical record of all health care the child receives including complete documentation of all EPSDT screening components and immunizations given.

HMOs may assume responsibility for some of the informing, tracking and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a "medical home" for children so that recipients under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from an emergency room. Therefore, DMAS strongly encourages MEDALLION PCPs to directly provide EPSDT services to the children in their panels. A PCP who chooses not to directly provide screening services must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. "Exhibits" at the end of this chapter contains an optional agreement form for this purpose. If the PCP does not use this optional form, the PCP must cover all the same provisions in the written agreement that he and the health department or other qualified EPSDT provider sign. The PCP and local health department must keep a copy of the agreement on file for audit purposes. Regardless of the screening arrangements, the PCP must continue to be responsible for the informing, tracking, follow-up and documentation requirements of EPSDT.

PROGRAM COVERAGE

The EPSDT Screening Periodicity Schedule

This Section describes the requirements of the EPSDT screening periodicity schedule for medical, vision, and hearing screenings. The required screening periodicity schedule is included under "Exhibits" at the end of this chapter. This schedule generally conforms to the American Academy of Pediatrics (AAP) current "Recommendations for Health Care Supervision " except for the frequency of screenings on children older than age ten (10). The required EPSDT childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP) and AAP is included under "Exhibits" at the end of this chapter.

The PCP or other screening provider must perform screenings on an outpatient basis including age appropriate immunizations on time at the ages shown. For example, the screening due when the child is six months old must be performed after he or she has reached the age of six months, but before the child reaches seven months of age. The screening scheduled for three years of age must be performed between the child's third and fourth birthdays. The PCP or other screening provider is obligated to follow the periodicity schedule and the specific protocol for each age group.

Federal EPSDT regulations require that States establish distinct periodicity schedules for medical, vision, hearing and dental screenings. The vision and hearing periodicity schedule has been combined with the medical screening schedule and should be completed during the same medical visit, if possible. The PCP, other screening provider or HMO must refer children three

(3) years of age and older for a complete dental screening by a Medicaid enrolled dentist. The Managed Care Help Line provides assistance on accessing dental services.

Scheduling Initial and Periodic Screenings

The PCP or other screening provider must ensure that the appointments scheduled for the initial and periodic screenings are timely. Initial screenings must be scheduled immediately on newborns. The screening provider must schedule all other initial screenings within **thirty (30) days** of notification of managed care assignment unless the family declines the services. The PCP or other designated screening provider must contact the family to schedule the initial appointment for an EPSDT screening. The PCP or HMO must maintain a screening periodicity tracking system on children seen for initial screening to ensure that the next screenings due are scheduled timely and families are contacted when next periodic screenings are due.

The PCP or other screening provider must follow up on missed appointments. If the child fails to keep the scheduled appointment, or the family fails to contact the provider to reschedule, a second appointment letter or telephone contact must be made providing the child another opportunity to be screened within thirty (30) days of the initial appointment. **Two (2) good faith efforts** are required to reschedule a screening appointment. A good faith effort is a successful contact by telephone or letter to the parents. Failure of the family to keep the second appointment and respond to the provider's attempted contact is considered a declination of that screening only. The provider must continue to maintain periodicity and schedule the child for the next screening due following the same process.

There are several exceptions to these screening timeliness requirements.

- **Initial screenings** - The initial screening time scheduled by the PCP or other screening provider may not correspond exactly to the periodicity schedule. After the initial screening, the subsequent periodic screenings must be performed on schedule.

- **Off-schedule screenings** - If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring him or her up-to-date at the earliest possible time.

- **Interperiodic screenings** - These are screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule. For example, the PCP may choose to screen adolescents ages 11-20 more in accordance with the AAP schedule rather than biannually as required by the DMAS periodicity schedule in "Exhibits" at the end of this chapter.

- Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an interperiodic screening be performed by the PCP or other screening provider. Examples of organizations whose professionals might make these requests include early intervention programs, Head Start, day care programs and WIC. In addition, the recipient or family may request an interperiodic screening at any time.

- **Partial screening** - Partial screenings are incomplete screenings in which one or more screening components is provided. The components that make up a complete screening are listed below and on the EPSDT periodicity schedule. If the child is uncooperative,

the parent(s) refuse to allow a component, the provider is unable to obtain a necessary specimen, or there are medical contraindications for providing a required component and a complete physical examination is performed during the visit, the screening will be considered complete for billing purposes. The child must be re-scheduled at the earliest opportunity to complete the other screening components.

Additional medically necessary EPSDT screenings, interperiodic screenings or partial screenings described above are not subject to prior authorization requirements. However, screenings not performed by the child's PCP require a referral from the PCP or a formal written agreement with another qualified screening provider if the child is enrolled in MEDALLION. Children not enrolled in managed care are not subject to this referral requirement.

EPSDT Screening Components

This Section describes the components of EPSDT screenings. The screenings have five federally required components that are described on page one. All components, including specimen collection, must be provided during the same screening visit.

Immunizations and laboratory tests may be billed separately from the screening visit. Objective vision and hearing testing performed during the same visit as the physical examination may **not** be billed separately. If hearing and vision testing needs to be performed separately from a physical examination, these procedures can be billed using the procedure codes listed in "Exhibits" at the end of this chapter.

The following is a description of each of the required age appropriate screening components:

Comprehensive Health and Developmental/Behavioral History

At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases).
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications)
- Nutritional history
- Immunization history
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home)
- Family background of emotional problems, problems with drinking or drugs or history of violence or abuse.

- Patient History of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports)

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate
- Menstrual history for females
- Obstetrical history, if appropriate

The history must be updated at each subsequent screening visit to allow serial evaluation.

Developmental/Behavioral Assessment

Assessment of developmental and behavioral status must be conducted at each visit by observation, interview, history and appropriate physical examination. If suspicious, objective developmental testing such as the Denver II Test should be administered. Objective developmental testing may only be billed separately by the screening provider if medical necessity for further objective developmental testing is documented in the child's record. The developmental assessment must include a range of activities to determine whether or not the child has reached an appropriate level of development using appropriate criteria for specific age groups described in the latest edition of the American Academy of Pediatric's (AAP) *Guidelines for Health Supervision*. Guidelines for developmental assessment from this publication are included in "Exhibits" at the end of this chapter.

A child age three (3) years of age and older must be referred to the local school system special education department for a developmental/psychological evaluation if he or she meets criteria for referral as defined by the objective test taken or exhibits any of the following behavior:

- Developmental delays
- History of poor school performance
- Poor social adjustment
- Emotional or behavioral problems.

A child exhibiting psychological/psychiatric problems may also be referred to the local behavioral health agency/Community Services Board or other qualified Mental Health Providers if school is not in session. A child younger than age three who exhibits developmental delay or a diagnosed condition that may result in developmental delay must be referred to the "Babies Can't Wait", Virginia's early intervention program, for a comprehensive developmental evaluation.

Comprehensive Unclothed Physical Examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques using the criteria for specific age groups described in the latest edition of the AAP *Guidelines for Health Care Supervision*. The examination must include all body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes

- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders)
- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be included as part of the complete physical examination at each screening visit beginning at age ten.

In addition, the height (or length) and weight of the child must be measured. When examining a child two (2) years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made.

For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it to the Department of Social Services' Hotline 1-800-552-7096 (*Code of Virginia* Section-63-248.3).

Appropriate Immunizations

The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current Childhood Immunization Schedule approved by ACIP and AAP and included under "Exhibits" at the end of this chapter. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that

warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

Laboratory Procedures

Age-appropriate laboratory procedures must be performed at intervals in accordance with the EPSDT screening periodicity schedule and AAP guidelines. The screening provider may bill for these laboratory procedures separately from the screening. The procedure codes for these procedures are listed under "Exhibits" at the end of this chapter. Specimen collection should be performed in-house at the screening visit. PCPs or other screening providers should avoid sending a child to an outside laboratory to have blood drawn or to obtain the necessary specimen.

The screening provider must comply with the Clinical Laboratory Improvement Amendments Act of 1988 commonly known as "CLIA". The provider must possess a certificate of registration or a certificate of waiver.

The following procedures on laboratory tests are required:

Neonatal Screening

The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia and other disorders performed prior to hospital discharge.

Sickle Cell Screening

The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six (6) month old visit if indicated in accordance with AAP guidelines.

Lead Toxicity Screening

EPSDT screening providers must comply with the following lead toxicity screening requirements issued by the Health Care Financing Administration (HCFA) *State Medicaid Manual* Part 5 - EPSDT Section 5123.2:

- A screening blood lead test must be administered on every Medicaid-eligible child at both the 12 and 24 month screening visit.
- A screening blood lead test must be administered on any child 36 and 72 months of age if the child previously has not been screened for lead poisoning.

Venipuncture is preferred for the screening blood test. Elevated capillary blood lead levels of 10μg/dl and above must be confirmed with venipuncture. The screening provider must measure the blood lead level at the nine (9) month visit if the infant is assessed to be at high risk for blood lead in accordance with AAP guidelines in "Exhibits" at the end of this chapter. Additional blood lead tests will be covered by Medicaid based on the physician's medical judgment. Any medically necessary diagnostic and treatment services will also be covered by Medicaid. The exhibit "Management of Children With Elevated Venous Blood Lead Levels" provides clinical guidelines for the management of children with elevated venous blood levels. These guidelines were developed by the Virginia Department of Health (VDH).

Blood lead samples should be submitted to a Medicaid-enrolled laboratory that maintains a proficient rating in the Cooperative Nationwide Blood Lead Proficiency Testing Program and participates in VDH blood surveillance system. The "Lead Safe Virginia Program" at (804) 225-4455 at VDH maintains a list of these laboratories. The "Lead-Safe Virginia Program" should be contacted if providers have questions regarding family education on lead, follow-up testing, environmental investigation of lead sources or clinical management of young children with elevated blood lead (EBL) levels. PCPs, HMOs and other screening providers must work with the local health department to assure provision of the following services for children with EBL:

- Nutritional and environmental hazard reduction counseling
- Developmental assessment and physical examination when appropriate per CDC guidelines
- Environmental investigation to identify sources of lead exposure

For more information, refer to the most current lead guidelines issued by the Centers for Disease Control (CDC), *Screening Young Children for Lead poisoning: Guidance for State and Local Public Health Officials and* the most recent AAP Policy Statement on S*creening for Elevated Blood Lead Levels*. Copies of the CDC guidelines are available free of charge from: Publications Activities, Office of the Director, National Center for Environmental Health and Injury Control, CDC, Mailstop F29, 1600 Clifton Road, NE, Atlanta, Georgia 30333 or call CDC toll free 1-888-232-6789. This document is also available on the following Internet address:

http:// www.cdc.gov/nceh/programs/lead/guide/1997/guide97.htm.

Anemia Screening

Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with EPSDT periodicity schedule in "Exhibits" at the end of this chapter.

Anemia screening, is a Medicaid reimbursable service, and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

Urinalysis

A dipstick urinalysis for leukocytes must be performed at screening visits in accordance with the EPSDT periodicity schedule under "Exhibits" at the end of this chapter.

Health Education

Health education related to the physical or dental assessment must be provided at each screening visit. It is designed to help children and their parents understand the health status of the child as well as provide information which emphasizes health promotion and preventive strategies. Health education explains the benefits of a healthy lifestyle, prevention of disease and accidents, and normal growth and development.

Health education has two components: anticipatory guidance and health supervision summary.

Anticipatory Guidance

Anticipatory guidance which includes discussion and counseling provides the family with information on what to expect in the child's current and next developmental phase. It emphasizes health promotion and preventive strategies. Anticipatory guidance is given in anticipation of health problems or decisions that might occur before the next periodicity visit. Anticipatory guidance topics to be considered for each visit include: health habits, prevention of illness and injury, nutrition, oral health, sexuality, social development, family relationships, parental health, community interactions, self-responsibility and school/vocational achievement. Topics may be discussed in groups or individually. Topics selected must be based on the needs of the individual child. The exact approach, topics selected, priority, and time allotted to any one topic will depend on the child's or adolescent's needs, the provider's professional judgment, and individual circumstances. The AAP *Guidelines for Health Supervision III* provides guidelines on topics to cover at each periodic screening visit.

Health Supervision Summary

The EPSDT screening provider must summarize the results of the screening and laboratory tests, review the child's health status, discuss any specific problems detected in the screening, and explain the need for referral one-on-one with the parents or directly with an older adolescent at the end of the screening visit. For children and their families not assessed at being at risk, an appointment must be made for the next regularly scheduled screening visit. Additional visits beyond those shown in the periodicity schedule must be scheduled, as appropriate, if medically indicated. The screening provider must advise the family that if there are major changes in health before the next scheduled visit, or if family stresses arise, a contingency visit may be arranged upon request.

Vision Screening

All Medicaid-eligible children must receive vision screenings. The purpose is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malformations, eye diseases, strabismus, amblyopia, refractive errors, and color blindness. Vision screenings have two components: subjective screening and objective screening.

The subjective screening is part of the comprehensive history and physical examination. As part of the subjective vision screening component, the history must include any eye disorders of the child or family, a history of any systemic diseases of the child or family which involve the eyes or affect vision, a history of the child's behavior that may indicate the presence or risk of eye problems, and a history of the child's medical treatment for any eye conditions. Children too young for the objective vision testing using a vision chart must receive a gross evaluation with the method documentation in the medical record. This is in addition to the eye assessment received during the physical examination.

The objective component does not replace the subjective vision screening component at every screening visit for infants and toddlers and must be performed in addition to it. Objective vision screening must include distance visual acuity, color perception, and ocular alignment tests. The screening provider must not bill for a vision screening on the same date as a medical screening. Vision screening is part of the complete physical examination of the child.

Vision screening must be performed beginning at age three in accordance with the EPSDT screening periodicity schedule in "Exhibits" at the end of this chapter. If the child is uncooperative at age three, the child must be rescreened in six months.

A list of acceptable distance visual acuity tests is presented below.

Recommended Eye Charts and Guidance

Lea Symbol Chart 10 Line (age 3-4) 15 Line (>age 5)
ETDRS Distance Chart
ETDRS Near Chart
Snellen "E" Charts
HOTV Chart

HEARING SCREENING

Virginia Law Regarding Hearing Screening at Birth

Virginia law requires that by July 1, 2000, all infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

EPSDT Hearing Screening

All Medicaid-eligible children must receive a hearing screening. The purpose is to detect sensorineural and conductive hearing loss, congenital abnormalities, noise-induced hearing loss, central auditory problems, or a history of conditions that may increase the risk for potential hearing loss. Hearing screening has two components: subjective and objective. Subjective hearing screening must be performed during every visit. In addition to subjective hearing screening, objective hearing screening must be performed at the prescribed intervals on the periodicity schedule. Regardless of the age of onset, all children with hearing loss require prompt identification and intervention by appropriate professionals with pediatric training and expertise.

Subjective

The subjective screening is part of the comprehensive history and physical examination. The history must include information about the child's response to voice and other auditory stimuli, speech and language development, chronic or current otitis media, and specific factors or health problems that place a child at risk for hearing loss.

The hearing of children who are at risk for progressive or late onset hearing loss should be monitored at least every six months until age three. Risk indicators include:

- Parent, care provider, or health care provider concerns regarding hearing, speech, language, or developmental delay based on observation and/or standardized developmental screening;
- Family history of hereditary, childhood sensorineural hearing loss;
- In utero infection (e.g., cytomegalovirus, rubella, herpes, toxoplasmosis, syphilis);
- Craniofacial anomalies including those with morphological abnormalities of the pinna and ear canal;
- Birthweight less than 1500 grams;
- Hyperbilirubinemia at a serum level requiring exchange transfusion;
- Bacterial meningitis;
- Apgar scores of 0 to four at one minute or 0 to six at five minutes;
- Ototoxic medications, including but not limited to the aminoglycosides, used in multiple courses or in combination with loop diuretics;
- Mechanical ventilation lasting five days or longer;
- Stigmata or other findings associated with a syndrome known to include a sensorineural hearing loss, a conductive hearing loss or both;
- Neurofibromatosis Type II or neurodegenerative disorders.
- Head trauma associated with loss of consciousness or skull fracture; and
- Recurrent or persistent otitis media with effusion for at least three months.

School-age children should have their hearing screened at ages 5, 10, 12, 16, and 18. The following risk factors suggest the need for hearing screening at other times:

- Parent, health care provider, teacher, or other school personnel concerns regarding hearing, speech, language, or learning disabilities;
- Family history of hereditary or delayed onset sensorineural hearing loss;

- Craniofacial anomalies including those with morphological abnormalities of the pinna and ear canal;
- Bacterial meningitis;
- Stigmata or other findings associated with a syndrome known to include a sensorineural hearing loss, a conductive hearing loss or both;
- Neurofibromatosis Type II or neurodegenerative disorders;
- Head trauma associated with loss of consciousness or skull fracture;
- Reported exposure to potentially damaging noise levels or ototoxic drugs; and
- Recurrent or persistent otitis media with effusion for at least three months.

Objective

For children over three years of age, pure tone screening using a pure tone audiometer or Welsh Allyn Audioscope must be conducted. Equipment must meet standards established by the American National Standards Institute (ANSI) and be calibrated yearly. Air conduction screening shall occur at the frequencies of 500, 1000, 2000, and 4000 Hertz.

Care should be taken to choose a site for testing that is in the quietest part of the office. Environmental noise levels should be low enough to allow a person with normal hearing to easily hear the pure tone frequencies through the ear phones.

Virginia Law, the American Academy of Pediatrics, and the American Speech-Language-Hearing Association provide the following information on objective screening methods for infants and toddlers:

Objective Testing Methods for Infants

There are two recommended physiologic methods of hearing screening for children six months of age and younger: auditory brainstem response (ABR*), non-automated or automated; and evoked otoacoustic emissions (EOAE*), non-automated or automated.

Objective Testing Methods for Toddlers

Two screening methods are suggested as the most appropriate tools for children who are functioning at seven months to three years developmental age: visual reinforcement audiometry (VRA) and conditioned play audiometry (CPA). For children from six months through two years of age, VRA is the recognized method of choice; as children mature beyond this age, CPA may be attempted. EOAE is suggested as an alternative procedure.

REFERENCES:

American Academy of Pediatrics
American Speech-Language-Hearing Association
Virginia School Health Guidelines
Bright Futures

***Definitions:**

Auditory brainstem response means an objective electrophysiologic measurement of the peripheral auditory system via acoustic click stimulation of the ear.

Automated auditory brainstem response means objective electrophysiologic measurement of the peripheral auditory system to acoustic stimulation of the ear, obtained with equipment which automatically provides a pass/refer outcome.

Evoked otoacoustic emissions means an objective physiologic response generated from the cochlea, and may include click evoked otoacoustic emission and/or distortion product otoacoustic emission test procedures.

Automated evoked otoacoustic emissions means an objective physiologic response from the cochlea, obtained with equipment which automatically provides a pass/refer outcome.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

EPSDT Optional Screening Procedures

The following is a description of **optional** screening procedures to be performed on children and adolescents at risk:

Tuberculin Test (Optional)

Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with the most recent *AAP Statement on Screening for Tuberculosis in Infants and Children* as described in "Exhibits" at the end of this chapter. The PPD test has replaced the Tyne method.

Cholesterol Screening (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with the most recent *AAP Statement on Cholesterol*, as described in "Exhibits" at the end of this chapter.

Sexually Transmitted Disease (STD) Screening (Optional)

All sexually active adolescents should be screened for sexually transmitted diseases such as chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer Screening (Optional)

A Papanicolaou (Pap) smear should be performed on all sexually active females at each screening visit.

Pelvic Examination (Optional)

All sexually active females should have a pelvic examination. A pelvic examination and a Pap smear must be offered as part of preventive health maintenance between the ages of 18 and 21.

DOCUMENTATION

The screening provider must retain copies of all screening claims and other Medicaid claims for at least five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. The PCP must maintain complete medical records on all children screened in his or her panel for at least five years from the date of service or as provided by applicable state law, whichever period is longer. Appropriate procedures and systems to ensure confidentiality must be in place. Medical records must contain the following information specific to EPSDT screening services:

- Reason for visit, e.g., screening, follow-up, sick visit. (Note the complaint and relevant history).

- The date screening services were performed, the specific tests or procedures performed, the results of these tests and procedures, and the specific staff member who provided the service. Each required component of screening including vision and hearing screening and immunizations must be documented separately. The DMAS-353 in "Exhibits" at the end of this chapter may be used for this purpose.

- Documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations.

- Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening.
- Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as a medical screening.

- Documentation of declination of screening services by parents.

- Documentation of missed appointments and of at least two good faith efforts to reschedule according to the periodicity schedule.

- Referrals made for diagnosis, treatment, or other medically necessary health services for conditions found in screenings and documentation of follow-up done to assure

services or treatment were provided within 60 days of the screening.

- Date next screening is due.
- Documentation of direct referral for age-appropriate dental services.

SPECIAL BILLING INSTRUCTIONS

Virginia Medicaid requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS/CPT) codes and definitions published in the current edition of the *Physician's Current Procedural Terminology* (CPT) in billing EPSDT covered screenings. The CPT Manual may be obtained by calling the America Medical Association at 1-900-621-8335. The Health Insurance Claim Form, HCFA-1500 (12-90) must be used to bill for screening services and immunizations. The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual*. Locators 24D and 24H are specific to EPSDT screening claims. **The appropriate procedure modifier is required in locator 24D for each CPT code for screenings**. The procedure codes and modifiers are listed under "Exhibits" at the end of this chapter. **The appropriate indicator "1" is required in locator 24H**.

MEDALLION referrals from the child's PCP are required for specialty care and other follow-up health care. Referral providers authorized by a child's PCP to provide treatment or other health services to that child must enter the **Medicaid Provider Identification Number of the PCP in Locator 17a** of the HCFA-1500 (12-90) in order to be reimbursed. Subsequent referrals resulting from the PCP's initial referral will also require the PCP's authorization and the PCP's Medicaid provider number in this block.

For children enrolled in HMOs, the HMO is responsible for payment of EPSDT screening services.

Billing for Complete Initial and Periodic Screenings

The standard preventive medicine services CPT procedure codes, as well as the appropriate modifiers listed in "Exhibits" at the end of this chapter, are used to bill for initial and periodic medical screenings (preventive health visits) provided on an outpatient basis.

The procedure codes for preventive health care visits must not be used if an unclothed physical examination is not performed during the screening. A complete medical screening must not be billed unless all required components including appropriate immunizations if due have been provided and have been documented in the child's medical record. The PCP may bill for a complete screening if a required component other than the unclothed physical examination is not performed because of a medical reason, child's lack of cooperation, or a parent's refusal. Parental refusal must be documented in the child's medical record with a signed and dated note from the parent.

Billing for Sick Visits

If a child is sick on the date of the scheduled screening and all required components are completed and documented, the screening provider may only bill for the initial or periodic screening using the appropriate CPT code (99381-99395) for a preventive health visit. The

screening provider may not bill for a separate office visit for treatment of the child's illness or condition on the date a complete screening is billed. If the screening provider is unable to complete the screening due to the child's illness or condition, the screening provider must document the treatment provided in the child's medical record and bill for the visit using the appropriate CPT codes for office visits. The screening provider must reschedule the child to complete the screening promptly.

Billing for Interperiodic and Partial Screenings

The preventive medicine CPT codes for established patients must be used to bill for interperiodic screenings if all the screening components due are provided. If a complete screening is not provided and only those screening components necessary to diagnose and treat the child's suspected condition are provided, the screening provider must use the evaluation and management CPT codes for office visits for established patients. These CPT codes must also be used for partial screenings when no unclothed physical examination is performed.

Billing for Hearing and/or Vision Screenings

The age-specific procedure codes for objective hearing and/or vision screenings are also included in "Exhibits" at the end of this chapter. The provider may bill for a vision screening **on a different date than the EPSDT medical screening** if an objective, age appropriate test is performed that meets the EPSDT requirements for hearing or vision screening. Since hearing and vision screening is a required part of a complete physical examination, these codes cannot be billed with or on the same date as the complete physical examination. These codes may be used by a screening provider to re-screen a child if the initial screening results were inconclusive and to provide hearing or vision interperiodic screening between or in addition to regularly scheduled screening visits. These codes may also be used by schools enrolled as Medicaid providers when objective vision and hearing testing is performed as part of mass screening activities or screening of children by school nurses or in school-based clinics.

Billing for Laboratory Tests

The screening provider may bill separately for laboratory tests that he actually performs as part of the screening and documents the service in the child's medical record. DMAS will only reimburse the provider actually performing the service (i.e., physician, independent laboratory, or other facility). The screening provider may bill for incurred handling and shipping charges on the HCFA-1500 (12-90) when the specimens are sent to an outside laboratory.

The required laboratory tests that must be performed during the EPSDT screening are:

- Hemoglobin/Hematocrit (age appropriate);
- Urinalysis (age appropriate);
- Blood Lead Screen; and
- Sickle Cell (as appropriate).

These codes are listed in "Exhibits" at the end of this chapter.

Billing for Childhood Immunizations

The Federal Vaccines for Children (VFC) Program provides routine childhood immunizations

free of charge to Medicaid-eligible children up to age 19. These vaccines are provided to VFC enrolled providers by the Virginia Department of Health (VDH). DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at 1-800-568-1929. DMAS will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC Program. DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). DMAS will reimburse the provider an $11.00 administration fee per injection. The VFC administration fee "Y" codes are listed in "Exhibits" at the end of this chapter.

HMOs are responsible for provider payments of immunizations furnished to children enrolled in HMOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to HMO enrolled children.

Reimbursement for Children Ages 19 and 20

Since EPSDT Federal regulations require states to provide coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The CPT procedure codes for vaccines provided to children ages 19 and 20 are included in "Exhibits" at the end of this chapter. The charges in locator 24F of the HCFA 1500 (12-90) claim form must reflect the actual acquisition cost per dose.

Office Visits Billed in Conjunction with Immunizations

DMAS will reimburse physicians an appropriate minimal office visit in addition to the VFC administration fee (or acquisition cost for adolescents ages 19 and 20 only) when an immunization is the only service performed.

VFC Coverage of Other Vaccines

The VFC program covers other vaccines not included in the ACIP immunization schedule including single antigen vaccines. These vaccines are included in "Exhibits" at the end of this chapter. If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification, which documents the medical necessity of providing a single antigen vaccine when the combined-antigen vaccine is available, must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by DMAS staff. The VFC Program also provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through VFC, the provider must provide medical justification. DMAS will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual "at risk".

VFC or Immunization Billing Questions

For questions relating specifically to the VFC program vaccines, call the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from

7:00 a.m. to 5:00 p.m. For billing questions, call the Medicaid Provider Help Line at 1-800-552-8627.

EPSDT REFERRALS

When an EPSDT screening indicates the need for diagnosis or treatment for a suspected condition or abnormality, the physicians' progress notes must so indicate. The child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment. If the screening provider is not the child's PCP, the screening provider must contact the child's PCP to request a referral and authorization for the treatment or other services.

Children who need refraction and glasses for visual problems or who have medical eye problems may be referred to an ophthalmologist or optometrist for the indicated follow-up eye care and glasses. A referral from the child's PCP is required for these treatment services. All referrals must be documented in the child's medical record.

A dated written referral must be given to the recipient or parents or forwarded to the referral service provider. The referral must include the following information:

- the name of the child
- the Medicaid ID number of the child
- the date of the screening
- the abnormality noted
- the name, address, telephone and fax number of the child's PCP (if different from the screening provider)
- the physician or other Health Care Provider to whom this referral applies
- the signature of the PCP or referring provider

The PCP must follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and document the results in the child's medical record.

The Omnibus Budget Reconciliation Act of 1989 requires states to reimburse for medically necessary services not otherwise covered under the *State Plan* for Medicaid-eligible children up to the age of 21 when such services are needed to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services, as long as the services are allowable under the *Social Security Act* 1905(a) and are pre-authorized by DMAS. Some non-*State Plan* services are available under Community Based Care Waivers. Providers may contact the DMAS Help Line for additional information at 1-800-552-8627.

OTHER RELATED PROGRAMS

BabyCare

To reduce Virginia's high infant mortality and morbidity rates, the Commonwealth implemented the BabyCare Program in 1988. The goals of the BabyCare Program are to remove barriers to care; to eliminate fragmentation and the lack of coordination in the delivery of care; and to assist the pregnant woman in accessing medical, social, educational and other services that may affect the pregnancy outcome. Pregnant women and infants who are identified by the PCP or other physicians as high-risk for poor medical outcomes may be referred to a BabyCare maternal and infant care coordinator (MICC) for the duration of the pregnancy, including 60 days postpartum and up to age two for infants. Expanded prenatal services that are available to high-risk pregnant women enrolled in Baby Care include:

- Classes which include such topics as body changes, danger signals, substance abuse, smoking cessation, labor and delivery, Lamaze, planned parenthood and child rearing;
- Nutritional assessment, nutrition counseling and follow-up;
- Homemaker services; and
- Blood glucose meters.

PCPs should complete the Infant Risk Screen forms on high-risk infants and refer them for MICC services. Medicaid will reimburse physicians for Infant Risk Screens. The risk screen must be properly documented with a copy of the completed signed risk screen form filed in the child's medical record. For more information about referrals and provider participation, contact the Medicaid Provider Help Line at 1-800-552-8627.

Federal regulations require EPSDT to coordinate services with Title V Maternal and Child Health programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) offered through VDH. Coordination requirements also include child health initiatives with other related programs such as, but not limited to, Head Start, Healthy Start, school-related health programs, and early intervention programs.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods and provides nutrition counseling to pregnant, postpartum, or breastfeeding women and children under age five with nutritional and financial needs. PCPs and EPSDT screening providers must refer Medicaid-eligible individuals in these categories to the local health department for additional information and eligibility determination.

Head Start

Head Start is a federally funded pre-school program which serves low-income children and their families.

There are four major components in Head Start as follows:

- Education—Head Start's educational program is designed to meet the individual needs of each child. It also aims to meet the needs of the community served and its ethnic and cultural characteristics;

- Health—Head Start emphasizes the importance of early identification of health problems. Since many children of low-income families have never seen a doctor or dentist, Head Start provides every child with a comprehensive health care program, including medical, dental, mental health, and nutritional services. The comprehensive EPSDT screening will meet the requirements of the Head Start Program health assessment;

- Parent Involvement—Parents are the most important influence on a child's development. Parents are encouraged to participate in the Head Start program as volunteers or paid staff as aides to teachers and other staff members. Many parents serve as members of Policy Councils and committees and have a voice in administrative and managerial decisions;

- Social Services—The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet those needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach; referrals; family needs assessments; providing information about available community resources and how to obtain and use them; recruitment and enrollment of the children; and emergency assistance and/or crisis intervention.

Healthy Start

Healthy Start is a grant program designed to enhance the existing perinatal health services for six areas within Virginia that have high need based on infant mortality, post neonatal mortality, teen pregnancy, and poverty statistics. The areas of Virginia include Norfolk, Portsmouth, Petersburg, Westmoreland County, Mecklenburg County and Clifton Forge/Covington. In addition, the funding expands the Fetal/Infant Mortality Review in each of the seven Regional Perinatal Coordinating Council areas and expands the Resource Mothers Program and nutrition services. Information about Healthy Start can be obtained by contacting the Healthy Start Program Coordinator at the VDH Division of Women's and Infant's Health at 1-804-786-9110.

Teen Pregnancy Prevention Program

The Teen Pregnancy Prevention Program is administered by the VDH Division of Child and Adolescent Health. This program is designed to reduce teen pregnancy in Virginia by assessing the problem, assuring program services with effective leadership and program development, and evaluation to promote replication of effective approaches. The major activities of this program include assessing and monitoring trends in adolescent pregnancy, providing community leadership for planning and policy development, providing quality assurance services for the seven local Teen Pregnancy Prevention Initiatives (TPPI) and Better Beginnings Coalitions (BBC) and assisting other communities to develop teen pregnancy prevention coalitions and programs.

Services provided include information and referrals, training for TPPI, BBC, parents, educators, physicians, community groups, and others and technical assistance. Teen Pregnancy Prevention Initiatives are located in seven Virginia Health Departments across the state, including Alexandria, the Eastern Shore, Crater Health District, Norfolk, Portsmouth, Richmond and Roanoke. Additional information about the Teen Pregnancy Prevention Program can be obtained by contacting the VDH Division of Child and Adolescent Health Teen Pregnancy Prevention Coordinator at 1-804-786-7367.

Family Planning Waiver Services (Effective October 1, 2002)

Family planning services may be available for women who received a Medicaid reimbursed pregnancy related service on or after October 1, 2002, who are less than 24 months postpartum, and who have income less than or equal to 133% the Federal Poverty Guidelines. (Women who do not meet the alien requirements for full Medicaid coverage and whose labor and delivery was paid as an emergency service under Medicaid are not eligible to participate in the Family Planning Waiver). Women enrolled in this waiver program are considered a specific Medicaid covered group and will only receive family planning services and sexually transmitted disease (STD) screening. Refer to the *Physician Manual,* Chapter IV, for a listing of specifically covered services. Additional information and eligibility determination is available at the local Department of Social Services.

Abstinence Education Initiative

The goal of this initiative is to reduce teen sexual activity and promote sexual abstinence until marriage. Funds support sex abstinence education programs, a media campaign, information and referral services, evaluation, and educational materials. Additional information may be obtained by calling 804-786-7367.

Fatherhood Campaign

The goal of the campaign is to improve health outcomes of children through father involvement. The campaign consists of skill building workshops, a resource center, community projects, and technical assistance. Additional information may be obtained by calling 804-786-7367.

Early Intervention Program

Early intervention services are identified in the Part C amendment to the Individuals with Disabilities Education Act (IDEA). Part C provides for a discretionary grant program for states to plan, develop and implement a statewide, comprehensive, coordinated, interagency system of early intervention services to infants and toddlers with disabilities and their families.

The goals of the Program are:

- To enhance the development of disabled infants and toddlers and to minimize their potential for developmental delay;
- To minimize the need for special education and related services after infants and toddlers with disabilities reach school age, and thereby reduce education costs;
- To minimize the likelihood of institutionalization for individuals with disabilities and

maximize their potential for independent living in society, and

- To enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities.

As defined in the regulations, "infants and toddlers with disabilities" means individuals from birth through age two (2) who need early intervention services because they are developmentally-delayed, or have a diagnosed condition that may result in developmental delay.

"Early intervention" includes a multi-disciplinary assessment and a written Individualized Family Services Plan (IFSP) developed by the multi-disciplinary team and the parents. Early intervention services include services such as audiology; case management services; family counseling and home visits; health services; medical services (for diagnostic and evaluation purposes only); nursing services; nutrition services; occupational therapy; physical therapy; psychological services; social work services; special instruction; speech-language pathology; and transportation. For more information, contact:

Babies Can't Wait Program
Virginia Department of Mental Health,
Mental Retardation and Substance Abuse Services
Early Intervention Office
Post Office Box 1797
Richmond, Virginia 23214

Telephone (804) 786-3710

PCPs and EPSDT screening providers must refer children under age three (3) with suspected developmental delay to the local early intervention program.

Resource Mothers Program

Teenagers are a group at high risk for poor birth outcome, both medically and socially. The Resource Mothers Program trains and supervises lay women to serve as a social support for pregnant teenagers and teenage parents of infants. The program is recognized for its role in bringing low-income pregnant teenagers into prenatal care and providing them with the support needed to make use of health care and other community services, to follow good health care practices, to continue in school, and to encourage the involvement of the infant's father and teens' parents to create a stable, nurturing home.

The Virginia Resource Mothers Program is a joint effort of the Department of Health, the Department of Medical Assistance Services, and local community agencies. DMAS currently supports 28 programs serving 70 localities across Virginia as a maternal outreach service. For further information, contact the Division of Women's and Infants' Health, Virginia Department of Health, (804) 371-4106.

Linkages with Schools

Schools are key links in improving child health because they are in regular contact with students

and parents. Schools play an important role in identifying children's health problems and improving access to a wide range of health care services.

Schools help to inform eligible children and families about Medicaid and the EPSDT Program. Participating schools inform their school population about the importance of preventive health care and encourage eligible children and families to participate in Medicaid and EPSDT. Through close interagency collaboration with Medicaid and EPSDT, the school setting has been used successfully as a key outreach and service delivery resource for the Medicaid-eligible school-age population.

RECIPIENT APPEALS OF THE DENIAL OF SERVICES

Any denial of a service decision made by DMAS staff may be appealed to the Department of Medical Assistance Services. This decision must be appealed in writing by the recipient or his or her legally appointed representative. If possible, please include a copy of the denial with the appeal request. All appeals must be filed within 30 days of the date of the final decision notification. Direct appeals to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

TABLE OF CONTENTS

APPENDIX 1
Virginia EPSDT Periodicity Schedule

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD				ADOLESCENCE				
AGE[1]	By1m	2m	4m	6m	9m	12m	15m	18m	24m	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY																				
Initial/interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																				
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•											
Blood Pressure										•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																				
Vision[2]	s	s	s	s	s	s	s	s	s	o[2]	o	o	s	s	o	o	s	s	o	s
Hearing[2]	s	s	s	s	s	s	s	s	s	o[2]	o	o	s	s	o	o	s	s	o	s
DEVEL/BEHAVIORAL ASSESSMENT[3]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[4]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES GENERAL																				
Hereditary /Metabolic Screening[5]	---•																			
Immunization[6]	---•	•	•	•		<---	---•---	--->			<--	--•---	--->			---•---	-------	-->		
Lead Screening					<--	--•			•											
Hematocrit or Hemglobin[7]	<----	-------	------	-------	--•											<---	-------	--•[7]--	------	---->
Urinalysis[8]												•				<---	-------	--•[8]--	------	---->
PROCEDURES-PATIENTS AT RISK																				
Tuberculin Test[9]						*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening[10]									*	*	*	*	*	*	*	*	*	*	*	*
STD Screening																s	s	s	s	s
Pelvic Exam[11]																*	*	*	-*---	->*
ANTICIPATORY GUIDANCE[12]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial Dental Referral[13]						<---	--------	---------	---------	--•										

[1]If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
[2]If the patient is uncooperative, rescreen within six months.
[3]By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
[4]At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
[5]Metabolic screening (e.g., thyroid, hemoglobinopathles, PKU, galactosemia) should be done according to State law.
[6]Schedule(s) per the Committee on Infectious Diseases, published periodically in Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations
[7]All menstruating adolescents should be screened.
[8]Conduct dipstick urinalysis for leukocytes for male and female adolescents.
[9]TB testing per AAP statement "Screening for Tuberculosis in Infant and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.
[10]Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
[11] A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between ages of 18 and 21 years.
[12] Appropriate discussion and counseling should be an integral part of each visit for care.
[13] Earlier initial dental evaluation may be appropriate for some children. Subsequent semi-annual examinations by a dentist

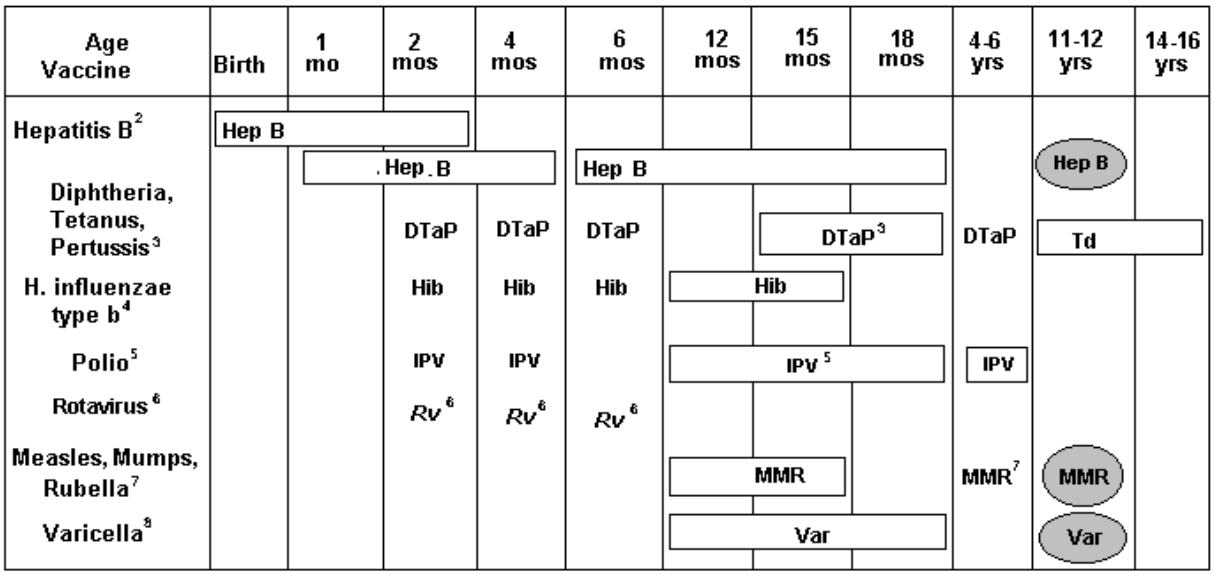
Key: • = to be performed * = to be performed for patients at risk s = subjective, by history o = objective, by standard testing method
<----------> = the range during which a service may be provided, with the dot indicating the preferred age.

OTE; ACIP Recommendation Dated October 12, `999

"The Advisory Committee on Immunization Practices (ACIP) recommended today that Rotashield, the only U.S.-licensed rotavirus vaccine, no longer be recommended for infants in the United States."

Recommended Childhood Immunization Schedule
United States, January - December 1999

Vaccines[1] are listed under the routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

[1]This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturer's package inserts for detailed recommendations.

[2]***Infants born to HBsAg-negative mothers*** should receive the 2nd dose of hepatitis B (Hep B) vaccine at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.
Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months of age.
Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test s positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).
All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

[3]Dtap (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the immunization series, including completion of the series in children who have received 1 or more doses of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DtaP. The 4th dose (DTP or DTaP) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and if the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 years.

[4]Three *Haemophilus influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax®[Merck]) is administered at 2 and 4 months age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.

[5]The ACIP now recommends that all four doses of poliovirus vaccine should be inactivated poliovirus (IPV). The ACIP recommended a sequential schedule of doses of IPV administered at ages 2 months, 4 months, 12-18 months and 4-6 years.

[6]Rotavirus (Rv) vaccine is shaded and italicized to indicate: (1) health-care provides may require time and resources to incorporate this new vaccine into practice; and (2) the AAFP feels that the decision to use rotavirus vaccine should be made by the parent or guardian in consultation with their physician or other health care provider. The first dose of Rv vaccine should be not be administered before 6 weeks of age, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at 7 months of age or older, and all doses should be completed by first birthday.

[7]The 2nd dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

[8]Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e., those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible children 13 years of age or older should receive 2 doses, given at least weeks apart.

EPSDT LEAD TOXICITY SCREENING QUESTIONS

Questions to assess risk status for lead poisoning.

Does your child:

- Spend time in buildings built before 1960 with peeling or chipping paint, including day care centers, preschools, or the homes of babysitters or relatives?
- Live in or regularly visit buildings built before 1960 with recent, ongoing, or planned renovation or remodeling?
- Have a brother or sister, housemate, or playmate being followed up or treated for lead poisoning (blood lead level >15 μg/dL)?
- Frequently come in contract with an adult whose job or hobby involves exposure to lead such as construction, welding, pottery, or other trades?
- Live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

If the answer to any of these questions is YES, the child is considered to be at risk of excessive lead exposure and should be screened with a blood lead test.

MANAGEMENT OF CHILDREN WITH ELEVATED VENOUS BLOOD LEAD LEVELS

BLOOD LEAD LEVEL (μg/Dl)	ACTION (Case managed assures coordinated action and follow-up)
<10	• Reassess or rescreen in 1 year.
10-14	• Provide nutritional and risk reduction education • Provide follow-up testing – venous, within 3 months. • Refer for WIC and social services, if needed.
15-19	• Begin clinical management. • Provide nutritional and risk reduction education. • Provide follow-up testing – venous, within 3 months. • Refer for WIC and social services, if needed. • Refer to health department for coordinated case management and environmental exposure source identification if 2 venous blood lead test results are in this range at least 3 months apart.
20-44	• Begin clinical management (complete medical evaluation, including developmental assessment). • Provide nutritional and risk reduction education. • For medical treatment information, contact the local health department or regional or regional treatment center listed below. Medical treatment (chelation) may be recommended at ≥35 μg/Dl on a case-by-case basis. • Refer to local health department for coordinated case management and environmental exposure source identification. • Provide follow-up testing – venous, every 2 months or more often as medically necessary. • Refer for WIC and social services, if needed.
45-69	• Within 48 hours, begin clinical management including medical treatment, complete medical evaluation, and developmental assessment. For medical treatment information, contact the local health department or regional treatment center listed below. • Provide nutritional and risk reduction education. • Refer to local health department for coordinated case management and environmental exposure source identification. • Provide follow-up testing – venous, once a month or more often as medically necessary. • Refer for WIC and social services, if needed.
70 and above	• Hospitalize child and begin medical treatment immediately. For medical treatment information, contact the local health department or regional treatment center listed below. • Begin clinical management (complete medical evaluation, including developmental assessment). • Provide nutritional and risk reduction education. • Refer to local health department for coordinated case management and environmental exposure source identification. • Provide follow-up testing – venous, once a month or more often as medically necessary. • Refer for WIC and social services, if needed.

Regional Treatment Centers	
Children's Hospital of the King's Daughters	(757) 668-7179
Medical College of Virginia	(804) 828-7010
University of Virginia	1(800) 451-1428

MANAGEMENT OF CHILDREN WITH ELEVATED VENOUS BLOOD LEAD LEVELS (continued)

If result of capillary screening test **(μg/dL) is:**	**Perform diagnostic test on venous blood within:**
10-19	3 months
20-44	1 week
45-59	48 hours
60-69	24 hours
≥70	Immediately as an emergency lab test

TUBERCULIN TEST (Optional)

Tuberculin testing using the Mantoux skin test should be performed in accordance with the most recent *AAP Statement on Screening for Tuberculosis in Infants and Children*.

Children for whom skin testing is required at initial screening:

- Contacts with persons with confirmed or suspected infectious tuberculosis children
- Children with radiographic or clinical findings suggesting tuberculosis
- Children immigrating from endemic countries
- Children with travel histories to endemic countries (e.g., Asia, Middle East, Africa, Latin America) and/or significant contact with indigenous persons from such countries

Children who require annual testing:

- Children infected with HIV
- Adolescents who have been previously incarcerated

Children who require testing every 2 years:

- Children exposed to the following individuals: HIV infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults and migrant farm workers.

Children who require testing at ages 4-6 and 11-16:

- Children whose parents immigrated (with unknown tuberculin skin test status) from regions of the world with high prevalence of tuberculosis, continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown tuberculin skin test status).
- Children without specific risk factors who reside in high-prevalence areas. Providers may contact their local health department to determine if the child resides in an area with appreciable tuberculosis rates.

CHOLESTEROL SCREENING (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with the most recent *AAP statement on Cholesterol*, if any of the following risk factors are present:

- Parents or grandparents with a history of coronary or peripheral vascular disease before 55 years of age (Obtain a fasting serum lipid profile that includes determination of the low-density lipoprotein [LDL] cholesterol.
- Parents with blood cholesterol level >240mg/dL (Obtain a non-fasting total blood cholesterol level; perform at least once).

If family history cannot be ascertained and any of the following risk factors are present in the family, screening shall be at the discretion of the health professional:

- Smoking
- Hypertension
- Physical activity
- Obesity
- Diabetes mellitus

DMAS-353

EPSDT MEDICAL HISTORY FORM

This form may be used in conjunction with the EPSDT Periodicity Schedule to document all components of screenings examination.

NAME_____ DOB_____ Check here if child is in foster care:_____

MOTHER'S NAME:	PHONE:	Allergies:
FATHER'S NAME:	PHONE:	
Family Medical History:		Hospitalizations/Surgery
Allergic Disorders:		
Blood Disorders:		
Cancer:		
Diabetes:		
Heart Disease/Hypertension:	Illnesses:	Date:
Seizure Disorder:		
Tuberculosis:		
Other(s):	Medications:	
Siblings:		
Person Medical History: BIRTH DATA: WT: Length: Type of delivery Apgar 1min_____Feeding 5min_____	HC:	

DMAS-353 A
EPSDT SCREENING DOCUMENTATION FORM

(N) = Normal or (-) negative findings. Abnormal or positive findings must be documented

NAME: _____ DOB:_____

AGE/DATE				
HT				
WT				
HC				
T P R				
FORMULA/DIET				
PERTINENT INTERVAL HISTORY				
EXAM				
Oral Inspection				
HEENT				
Chest				
Heart				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Endocrine				
Skin				
Lab				
Hematology (Hbg/Hct)				
Blood lead				
Urine				
Sickle Cell				
Other				
NUTRITION				
VISION SCREENING				
HEARING SCREENING				
REFER TO DENTIST				
GROWTH AND DEVELOPMENT				
PERTINENT PROBLEMS/EXAM ABNORMALITIES				
IMPRESSION				
HEALTH EDUCATION AND ANTICIPATORY GUIDANCE				
REFERRALS				
PHYSICIAN'S SIGNATURE:				
DATE				
NEXT SCREENING APPT				

EPSDT SCREENING
PROCEDURE CODES

DESCRIPTION	Age	CPT Code
INITIAL SCREENINGS		
NEW PATIENT	less than 1 year of age	99381
NEW PATIENT	1-4 years of age	99382
NEW PATIENT	5-11 years of age	99383
NEW PATIENT	12-17 years of age	99384
NEW PATIENT	18-20 years of age	99385
PERIODIC SCREENINGS		
ESTABLISHED PATIENT	less than 1 year of age	99391
ESTABLISHED PATIENT	1-4 years of age	99392
ESTABLISHED PATIENT	5-11 years of age	99393
ESTABLISHED PATIENT	12-17 years of age	99394
ESTABLISHED PATIENT	18-20 years of age	99395
VISION SCREENINGS		
VISION	0-3 years of age	Z9530
VISION	4-5 years of age	Z9531
VISION	6-20 years of age	Z9532
HEARING SCREENING		
HEARING	0-23 months	Z9540
HEARING	2-3 years of age	Z9541
HEARING	4-20 years of age	Z9542

The appropriate EPSDT procedure modifiers listed below required for each EPSDT CPT/HCPCS procedure code.

MODIFIER CODE

H	No abnormalities found, no treatment required, and no referral required
K	Abnormality found, treatment has been initiated by myself, and no other referral required
T	*Abnormality found, treatment has been initiated by myself, and referral to another practitioner has been made
U	*Abnormality found, no treatment has been initiated by myself, and referral to another practitioner has been made
W	Abnormality found, no treatment has been made at this time, referral to myself for treatment within the next 120 days
Y	Abnormality found, treatment/referral has been refused by the recipient or the responsible adult in the case
Z	Abnormality found, no treatment has been initiated, no referral has been made. The recipient is already under care.

PROCEDURE CODES FOR OTHER EPSDT TESTS

DESCRIPTION	CPT CODE	SPECIMEN HANDLING (IF SENT TO OUTSIDE LAB)
		CPT Code
HEMOGLOBIN AND HEMATOCRIT – Blood Count; automated (RBC, WBC, Hgb. Hct and indices only)	85021	99000
HEMOGLOBIN AND HEMATOCRIT - Blood Count; hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	85031	99000
TUBERCULOSIS SKIN TEST (PPD), intradermal	86580	
BLOOD LEAD*	83655	99000
SICKLE CELL – Hemoglobin electro-phoresis*	83020	99000
URINALYSIS – routine, without microscopy, non-automated	81002	99000

The screening provider must possess CLIA certification to bill for laboratory CPT codes.
*Laboratory must be certified in this process.

VACCINES FOR CHILDREN (VFC)
EPSDT IMMUNIZATION SCHEDULE PROCEDURE CODES

DESCRIPTION	VFC Code Ages 0-18	CPT Code Ages 19-20
Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP)	Y0014	90700
Tetanus and diphtheria toxoids (Td)	Y0015	90718
Poliomyelitis vaccine (IPV)	Y0022	90713
Poliovirus vaccine, live oral (any type(s)) (OPV)	Y021	90712
Immunization, active, hepatitis B vaccine, newborn to 19 years	Y0020	90744
Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use	Y0018	90645
Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use	NA	90646
Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	Y0018	90647
Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use	Y0018	90648
Varicella (chicken pox) vaccine	Y0028	90716
Rotavirus Vaccine	Spring 1999	90680
Measles, mumps and rubella vaccine live (MMR)	Y0023	90707

VACCINES FOR CHILDREN (VFC)
ADDITIONAL VACCINES COVERED UNDER VFC

DESCRIPTION	VFC Code Ages 0-18	CPT Code Ages 19-20
Diphtheria and tetanus toxoids (DT)	Y0016	90702
Diphtheria, tetanus toxoids, and whole cell pertussis (DTP) and Hemophilus influenza B (HIB) vaccine (	Y0017	90720
Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use (TriHIBit)	Y0034	90721
*Mumps virus vaccine, live **Medical justification must be attached documenting the medical necessity for administering a single-antigen vaccine*	Y0026	90704
*Measles virus vaccine, live attenuated **Medical justification must be attached documenting the medical necessity for administering a single-antigen vaccine*	Y0025	90705
*Rubella virus vaccine, live **Medical justification must be attached documenting the medical necessity for administering a single-antigen vaccine*	Y0027	90706
Measles and rubella virus vaccine, live	Y0024	90708
Rubella and mumps virus vaccine, live	NA	90709
Immunization, active, hepatitis B vaccine 20 years and above	NA	90746
Immunization, active, hepatitis B vaccine Dialysis or immunosuppressed patient, any age	Y0032	90747
Influenza virus vaccine	Y0029	90724
Influenza virus vaccine, split virus, 6-35 months dosage	Y0029	90657
Influenza virus vaccine, split virus, 3 years and above dosage	Y0029	90658
Influenza virus vaccine, whole virus, 12 years and above	NA	90659
Pneumococcal vaccine, polyvalent	Y0030	90732
Pneumococcal conjugate vaccine, polyvalent, for intramuscular use	NA	90669
Immunization, active, hepatitis B and Hemophilus influenza B (HIB) vaccine (COMVAX)	Y0033	90748
Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for intramuscular use	Y0035	90633

AGREEMENT BETWEEN PRIMARY CARE PROVIDER AND EPSDT PROVIDER TO PROVIDE EPSDT SCREENING SERVICES TO MEDALLION PATIENTS

In order to provide coordinated care to those children who are enrolled in MEDALLION and obtain primary care services from _____ and EPSDT screening services including immunizations from _____, the undersigned agree to the following provisions.

Primary Care Provider agrees to:

1. Refer MEDALLION patients (ages _____) to _____ for EPSDT screening appointments. If the patient is in the office, the physician/office staff will assist the patient in making an EPSDT screening appointment with the HD.

2. Maintain, in the office, a copy of the physical examination, documentation of all required EPSDT screening components completed and immunization records as a part of the patient's permanent record.

3. Monitor the information provided by _____ to assure that patients in the MEDALLION program are receiving complete EPSDT screening services including immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits, immunizations on follow-up.

4. Review information provided by the _____ and follow up with the family when suspected conditions are found and additional services are needed. Refer the patient for medically necessary specialized testing or treatment and obtain the results.

5. Provide the Department of Medical Assistance Services Managed Care Unit at least thirty (30) days advance notice if the Primary Care Provider and/or the HD wishes to discontinue this Agreement.

6. Provide to the EPSDT Provider a monthly list of MEDALLION patients assigned to your panel that are eligible to receive EPSDT services.

The EPSDT Provider agrees to:

1. Provide age appropriate complete EPSDT screenings including immunizations in accordance with the most current Virginia EPSDT Periodicity Schedule within thirty (30) days of the notification or request on patients who are referred by the PCP or are self-referred.

2. Send complete documentation of EPSDT screenings including immunization records on each patient screened and/or immunized monthly to the Primary Care Provider.

3. Notify the Primary Care Provider of significant findings on the EPSDT screening within twenty-four (24) hours. Refer a patient needing immediate medical care to the Primary Care Provider for treatment or referral for specialized care. Obtain prior authorization from the Primary Care Provider for any specialized testing or treatment.

4. Provide the Department of Medical Assistance Services MEDALLION Unit thirty (30) days advance notice if the Primary Care Provider and/or the HD wishes to discontinue this Agreement.

_____ _____ _____
Signature of **Primary Care Provider** or Authorized Official Date PCP Medicaid Provider #

_____ _____
Printed Name of Provider or Authorized Official Provider Group Name (if applicable)

_____ _____ _____
Signature of **EPSDT Provider** or Authorized Official Date Medicaid Provider #

_____ _____
Printed Name of Provider or Authorized Official Provider Group Name (if applicable)